

# Inpatient or Outpatient Only: Why Observation Has Lost Its Status

## WHITE PAPER



by Kimberly Anderwood Hoy,  
JD, CPC, director of Medicare  
and compliance at HCPro, Inc.

Proper patient status classification affects the clinical and financial success of hospitals. Unfortunately, assigning accurate patient status (e.g., inpatient or outpatient) is no small task, although it is an incredibly important one.

Patient status affects reimbursement methodology and reimbursement amounts for facilities. It affects copay amounts for patients and can affect coverage for skilled nursing facility care. Improper status assignment will likely mean more attention from the government and its contractors—facilities have paid deep penalties for incorrectly billing for inpatient services in false claims cases—and Medicare recovery audit contractors are paying close attention as well.

Per the Social Security Act and 42 CFR 1004.10, Medicare providers may only provide services that are reasonable, economical, and medically necessary and are of a “quality meeting professionally recognized standards of healthcare.” And hospitals must have a utilization review (UR) plan in effect to review the Medicare services the hospital provides.

### Inpatient status

Getting Medicare patient status correct lies in understanding the definitions. Medicare has very specific definitions of inpatient care and observation services (provided to outpatients). These definitions must guide the patient status decision-making process for Medicare patients, and many hospitals elect to use these same definitions for all their patients.

The *Medicare Benefit Policy Manual* describes an inpatient as a person admitted to a hospital for bed occupancy to receive inpatient hospital services. A patient is generally an inpatient when formally admitted as such with the expectation that he or she will remain at least overnight.

It is irrelevant whether the patient is transferred, discharged, or even dies, thereby not actually using the bed overnight. And the fact that a patient remains at the hospital overnight does not automatically make him or her an inpatient. He or she may be an outpatient that requires extended recovery from a procedure or observation services.

Factors influencing the decision to admit a patient as an inpatient include:

- The patient’s medical history and current medical needs
- The types of facilities available to inpatients and outpatients

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- Hospital bylaws and admissions policies
- Relative appropriateness of treatment in each setting
- Severity of signs and symptoms
- Medical probability of an adverse outcome
- The need for and availability of diagnostic studies to assist in assessing whether to admit the patient

Medicare considers the decision to admit a patient a complex medical judgment made by the patient's attending physician. The physician should consider all the factors listed above when determining the most appropriate setting for the patient's care.

Medicare also expects the hospital to help physicians make this decision through its UR staff, which can provide education and real-time assistance in determining the correct placement of the patient.

### Outpatient observation

The physician may make the inpatient admission decision immediately when the patient enters the hospital or may "observe" the patient in outpatient status for a period of time until he or she has sufficient information to make the decision. In fact, Medicare defines observation as a service provided while the decision to admit or discharge home is being made.

Per the *Medicare Benefit Policy Manual*, the definition of observation care is as follows:

*Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.*

The *Medicare Benefit Policy Manual* further notes that observation is common for patients who present to the emergency department (ED) and require a significant period of treatment or monitoring before physicians can decide whether to admit or discharge them.

In recent years, many hospitals viewed observation as a patient status option, falling in between outpatient status and inpatient status.

- Observation is a common outpatient service, but it is often rendered in hospital beds that are also used for inpatient care. This has led to some confusion about whether observation is a status. In recent years, many hospitals viewed observation as a patient status option, falling in between outpatient status and inpatient status. However, CMS considers observation services as one of many types of outpatient services (e.g., ED and clinic visits, diagnostic testing, and therapeutic services).

This was emphasized in *Transmittal 1745*, dated May 22, in which CMS attempted to clarify matters by stating that there is no payment status called "observation," but that observation care is an outpatient service ordered by

a physician and reported with HCPCS code G0378. CMS has suggested it would be more accurate to refer to “observation status,” which does not actually exist, as “observation services”—a change in language that will likely take time for the industry to adopt fully.

Unlike inpatient care billed by the day, observation services are billed by the hour. Observation should not typically last more than 48 hours. The physician should be able to determine whether to admit a patient as an inpatient in less than 24 hours and should have a clear decision to admit or discharge within 48 hours.

CMS has limited coverage of observation hours under Medicare to 48 except in rare and exceptional cases when more hours are reasonable and necessary. However, many state Medicaid agencies and third-party insurers limit observation to 24 hours. Hospitals should use care in applying this Medicare policy to patients with other insurers as more than 24 hours may not be billable.

For billing purposes, observation hours begin at the time observation services are initiated as documented in the medical record. This may, but does not always, coincide with the patient being placed in an “observation bed.”

Observation hours end when clinical or medical interventions, including follow-up care after a physician releases the patient, are finished. Providers may round to the nearest hour (e.g., 14 hours and 17 minutes would count as 14 hours for billing purposes, whereas 10 hours and 38 minutes would count as 11 hours) when counting observation hours.

Hours of observation care are billable to Medicare only when they meet coverage requirements. For Medicare to cover observation services, the *Medicare Benefit Policy Manual* and the *Medicare Claims Processing Manual* require the following:

- A physician order by an individual authorized under state law and hospital bylaws to admit patients or order outpatient tests
- Timed, written, and signed initial, discharge, and other appropriate progress notes from the physician
- An explicitly documented assessment stating that the patient would benefit from observation care

The term “admit to observation” should be avoided, as well as the general term “admit.” Admission generally denotes inpatient admission and services.

● The physician order should clearly express the physician’s intent for observation services and state the care required (e.g., “outpatient observation” with a listing of observation care orders). The term “admit to observation” should be avoided, as well as the general term “admit.” Admission generally denotes inpatient admission and services.

Medicare will not cover observation services provided under the following circumstances:

- The services were provided for the convenience of a patient, his or her family, or the physician
- An inpatient admission would have been appropriate
- The services provided are standard for diagnostic, surgical, or therapeutic services
- They are part of the standard preparation or recovery period for diagnostic, surgical, or therapeutic services
- The monitoring is incident to other diagnostic, surgical, or therapeutic services

If any of this noncovered care is provided, regardless of whether the hospital calls it “observation,” it should not be billed to Medicare as observation.

For example, standard recovery following a procedure may require the use of a hospital bed for a short time to observe the patient. However, this is considered recovery care and should be billed to Medicare as recovery and not as observation. Additionally, if any of the above occurs during an otherwise covered period of observation, hospitals should not include time spent on them in their hours of observation care billed to Medicare.

### Condition code 44

When a physician determines that a patient requires inpatient admission while receiving observation care, the physician can convert the patient to an inpatient status. The physician must document the medical necessity in the record and write the corresponding order to admit.

But correcting a situation in which a physician admits a patient as an inpatient when the patient should have received outpatient services is more complicated. Using condition code 44 is the only way to correct an inappropriate inpatient status assignment. CMS outlined requirements for use of condition code 44 in *Transmittal 299*, “Condition code 44—Inpatient admission changed to outpatient.” Condition code 44 allows providers to bill the entire episode of care as though the patient was registered as an outpatient.

CMS notes the following regarding the use of condition code 44 in the *Medicare Claims Processing Manual*:

*Condition code 44 is intended to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria.*

CMS is careful to note it does not intend condition code 44 to take the place of adequate staffing or physician education on hospital policies and admission protocols.

- CMS is careful to note it does not intend condition code 44 to take the place of adequate staffing or physician education on hospital policies and admission protocols. In fact, CMS expects hospitals to continually educate staff members on these topics and expects condition code 44 to become increasingly rare as a result.

According to the *Medicare Claims Processing Manual*, providers may use condition code 44 when all of the following are met:

- The hospital's UR committee physician decides an inpatient does not meet inpatient criteria
- A physician must concur—either the attending physician or another UR committee member
- The decision is appropriately documented in the medical record by the UR committee and the attending physician, if he or she approves
- The status change occurs prior to patient discharge and claim submission

When a provider meets condition code 44 billing criteria, Medicare will pay for the services under the outpatient prospective payment system. Providers should bill all charges as outpatient (i.e., with HCPCS codes) and with condition code 44 using bill type 013X (i.e., hospital outpatient claim).

If condition code 44 criteria are not satisfied but UR obligations are met, providers may bill for procedures and diagnostic tests (e.g., diagnostic x-rays; laboratory tests; physical, occupational, and speech therapy services; certain surgical dressings, casts, and splints; some radiation therapy supplies or services; some vaccines; and others) as outpatient services provided to an inpatient using bill type 012X. Inpatient room charges were not medically necessary and thus would not be covered or paid on a 012X bill.

### Billing observation under condition code 44

There is a great deal of confusion regarding billing hours of observation when a case that was initially inpatient is changed to outpatient using condition code 44 procedures.

There is a great deal of confusion regarding billing hours of observation when a case that was initially inpatient is changed to outpatient using condition code 44 procedures. Some hospitals believe CMS intends the inpatient hours from the time of the original admission order to be converted to observation, whereas others believe the observation hours begin at the time the patient status is changed to outpatient and the observation order is written.

CMS' current language regarding billing condition code 44 states that the entire episode of care should be billed as outpatient; however, CMS does not instruct hospitals at all related to converting services rendered to observation services for billing purposes.

CMS' language would seem to indicate that any service rendered during the episode of care should be billed under the outpatient billing, coding and coverage rules.

For example, if the patient had an x-ray prior to conversion to an outpatient, this x-ray would be billable on a revenue code line with an HCPCS code, in accordance with any outpatient edits and policies that might exist. An order for the x-ray would be required, and it would be subject to the outpatient medical necessity coverage rules like any other outpatient x-ray. If you apply

the same analysis to the observation services, they would be billed as outpatient services on a revenue code line for observation with the appropriate observation HCPCS code.

Further, the *Medicare Claims Processing Manual*, Chapter 4, §290.4.1, states that G0378 (i.e., the HCPCS code for observation) is used when observation services are “ordered and provided.” The word “ordered” was recently added for clarification in *Claims Processing Manual Transmittal 1760*, effective July 1. This transmittal indicates that observation services require an order to be billed, and therefore, the time is calculated from the time the services are ordered, meaning the hours prior to the order should not be counted.

National Government Services (NGS), the MAC for jurisdictions 8 (Wisconsin and Indiana) and 13 (New York and Connecticut), recently questioned its CMS representative about this issue, and the representative confirmed this opinion. NGS shared the following with me in an e-mail:

*We received confirmation from our CMS representative that indeed, a written order for observation status is required and that the inpatient stay cannot be converted to observation time when CC 44 is applicable. If the physician (or UR committee in conjunction with the physician) deems the patient meets observation criteria after conversion to outpatient status, then observation time may be billed if the level of care is met. But observation time would begin when the order is written; and the previous (although incorrect) inpatient time could not be billed as observation. The services rendered while the patient was placed in inpatient status would be billed as outpatient services, but no observation time could be billed.*

Although this confirmation is applicable only to the NGS jurisdictions, note that NGS received this clarification from CMS.

Additionally, since that time, Noridian Administrative Services, the MAC for jurisdictions 3 and 6, has also confirmed to providers in its jurisdiction that this is the correct billing for the observation hours.

If providers receive conflicting advice from their MAC, I would encourage them to use caution in billing any hours of observation without a proper order for observation services, especially in light of CMS' confirmation to NGS.

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